No. 665

# In the Supreme Court of the United States

OCTOBER TERM, 1941

HARRIET V. PENCE, PETITIONER

*v.*

UNITED STATES OF AMERICA

*ON MOTION FOR LEAVE TO PROCEED IN FORMA PAUPERIS AND ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE SEVENTH CIRCUIT*

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### OPINIONS BELOW

The opinion of the district court (R. 219–222) is not reported. The opinions of the circuit court of appeals (R. 249–256) are reported in 121 F. (2d) 804.

### JURISDICTION

The judgment of the circuit court of appeals was entered on July 2, 1941 (R. 257) and a petition for rehearing was denied on August 4, 1941 (R. 258). The petition for a writ of certiorari was filed on September 29, 1941. The jurisdiction of this Court is invoked under section 240 (a) of the Judicial Code, as amended by the Act of February 13, 1925.

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## QUESTIONS PRESENTED

1. Whether the evidence requires a finding that the insurance policy sued on was obtained by fraud.

2. Whether, because of lack of timely compliance with the provisions of its Rule 9, requiring the filing of a statement of points, the circuit court of appeals was without jurisdiction to permit late compliance with the rule and to hear and determine the appeal on its merits.

## PERTINENT RULES OF COURT

Rule 9 of the Circuit Court of Appeals for the Seventh Circuit provides in part as follows:

> 1. Where an appeal is taken to this court, the appellant shall file with the clerk of the district court, for inclusion in the record on appeal, a statement of points which shall set out separately and particularly each error asserted and intended to be urged. No appeal shall be considered, unless such a statement of points shall have been so filed.

Rule 75 (h) of the Rules of Civil Procedure for the district court provides:

> POWER OF COURT TO CORRECT RECORD. It is not necessary for the record on appeal to be approved by the district court or judge thereof, but, if any difference arises as to whether the record truly discloses what occurred in the district court, the difference shall be submitted to and settled by that court and the record made to conform to the truth. If anything material to either party is omitted from the record on appeal by error or accident or is misstated therein, the parties by stipulation, of the district court, either before or after the record is transmitted to the appellate court, or the appellate court, on a proper suggestion or of its own initiative, may direct that the omission or misstatement shall be corrected, and if necessary that a supple-

mental record shall be certified and transmitted by the clerk of the district court.

## STATEMENT

Petitioner, widow and beneficiary of insured (R. 2, 3), brought suit on a contract of United States Government life (converted) insurance, issued to Lawrence W. Pence on July 1, 1927. The insured, an eye, ear, nose and throat specialist, was a medical officer in the military service of the United States from August 7, 1918, to January 9, 1919 (R. 14), and during that period he obtained a $10,000 contract of yearly renewable term insurance which lapsed for nonpayment of the premium due February 1, 1920 (R. 14).

The policy now sued on was obtained by reinstatement and simultaneous conversion of the lapsed term policy (R. 169–181, 206–207). Premiums were paid on the converted policy from the date of its issuance in 1927 through the month of August 1934. The insured died on September 21, 1934, during the grace period of 31 days allowed for payment of the premium due on September 1, 1934 (R. 14–15). The only issue presented in the district court was raised by the Government's affirmative defense that the policy was void because obtained by fraud (R. 10).

A jury trial on this issue resulted in a verdict for the petitioner (R. 218). Respondent's motion for a directed verdict, made after all of the evidence had been introduced (R. 157), and its motion for judgment, made after the verdict was returned (R. 215, 217), upon the ground that the evidence required a finding in its favor, were denied (R. 213). Judgment on a verdict in petitioner's favor was entered on May 28, 1940 (R. 223–225). Notice of appeal was filed on August 26, 1940 (R. 227) and the record was filed in the court below on November 23, 1940, within the time allowed by order of the district court entered on September 30, 1940 (R. 227, 228).

On February 15, 1941, petitioner moved in the court below for dismissal of the appeal on the ground that the record did

not include a statement of the errors to be asserted, required by Rule 9 of that court. On February 28, 1941, a statement of errors to be asserted was filed by the respondent and, by leave of court, made a part of the record on appeal (R. 233); the motion to dismiss was then denied (R. 247, 249–250). The court below further held that the evidence on the issue of fraud required, as a matter of law, a finding in favor of the respondent and, accordingly, that the district court erred in denying respondent's motion for a directed verdict. The judgment was reversed and the case remanded for further proceedings in harmony with the holding of the court below (R. 249–256).

## ARGUMENT

1. Petitioner urges (Pet. 13) that the court below was in error in holding that the trial court should have granted the respondent's motion for a directed verdict.[1]

An applicant for insurance has an absolute duty to disclose in good faith, fully, and fairly matters which he knows concerning his health. *Stipcich* v. *Metropolitan Life Insurance Co.*, 277 U. S. 311; *United States* v. *Elliott*, 73 F. (2d) 374 (C. C. A. 5), certiorari denied, 295 U. S. 740. Violation of this duty occurs when, in applying for a policy, the insured (a) makes untrue statements (b) material to the risk (c) with knowledge that they are untrue, or (d) without reasonable regard as to their truth or falsity. When such untrue statements are relied upon by the insurer, recovery on the policy is barred without further proof of actual conscious design to defraud. *Metropolitan Life Ins. Co.* v. *Hilton-Green*, 241 U. S. 613, 622; *Claflin* v. *Commonwealth Ins. Co.*, 110 U. S. 81, 85, 95; *Aetna Life Ins. Co.* v. *Perron*, 69 F. (2d) 401, 403 (C. A. A. 7); *United*

[1] Petitioner also contends (Pet. 13) that the action of the court below on the issue of fraud violated the Seventh Amendment to the Constitution and Rule 50 (b) of the Rules of Civil Procedure for the District Courts of the United States. The contention, however, is based upon the substantive proposition that there was sufficient evidence for the jury, and, in effect, raises only the question set out above.

*States* v. *Depew*, 100 F. (2d) 725, 728 (C. C. A. 10); *Nonantum Investment Co.* v. *Maryland Casualty Co.*, 56 F. (2d) 329, 335 (C. C. A. 1). Specific information requested by the insurer and related to the risk is material as a matter of law. *Perkins* v. *Prudential Life Ins. Co.*, 69 F. (2d) 218, 220 (C. C. A. 7); *Aetna Life Ins. Co.* v. *Bolding*, 57 F. (2d) 626 (C. C. A. 5); *Hesselberg* v. *Aetna Life Ins. Co.*, 75 F. (2d) 490, 493 (C. C. A. 8).

The policy sued on was issued pursuant to the insured's application, dated June 21, 1927, for reinstatement of his yearly renewable term insurance which had lapsed for nonpayment of the premium due on February 1, 1920 (R. 169–174), and his contemporaneous application for conversion of the reinstated policy (R. 206–207). As a condition to the reinstatement of the insurance, the insured certified in his application for reinstatement as true to the best of his knowledge and belief (1) that he had not been ill or consulted a physician with regard to his health since the lapse of his term insurance (R. 169); (2) that he had never been treated for any condition of the heart or blood vessels, or stomach or intestines (R. 171); and (3) that since the lapse of his insurance he had not been prevented by reason of ill health from attending his usual occupation (R. 169).

The evidence establishes that these statements were untrue; that they were known by the insured to be untrue at the time he made them; that they were material to the risk; and that they were relied upon by the Government in issuing the policy.

The insured was treated for a severe attack of sinusitis and ethmoiditis from January 16 to 25, 1927. he insured, himself an eye, ear, nose, and throat specialist, expressly recognized the attack as a recurrence of a chronic condition (R. 109–110, 120, 204, 208–209, 214). Dr. Burke discussed the insured's condition with him and advised him regarding it in 1922 and 1923 (R. 125, 204). That this sinus condition was

both severe and chronic in character is shown by the testimony of Dr. French, who treated the insured in 1919 (R. 124); by a number of written statements of the insured signed by him between 1928 and 1933 (R. 184, 185, 187, 189, 200, 202, 204, 208, 209); and by evidence that the condition recurred periodically until the time of the insured's death (R. 78, 190).

On April 6, 1925, the insured sought and obtained a gastro-intestinal examination which resulted in a diagnosis of suspected duodenal pathology (R. 196). Written statements of the insured reflect that abdominal distress was experienced by him as early as 1919; that it was regarded by him to be duodenal ulcer as early as 1920 (R. 19); and that the symptoms recurred periodically thereafter until his death (R. 186, 187, 191, 204).

As early as 1918, while still in the military service, the insured was treated for a condition then diagnosed as myocarditis. The symptoms continued thereafter until his death (R. 97, 202, 204, 208, 210–211). After his discharge from military service in 1919, the insured resumed his private practice of medicine, but abandoned it in 1925 to accept a salaried position in the United States Veterans' Bureau because the strain and exposure of private practice were found to aggravate his condition (R. 208–209; Cf. R. 126, 177, 189).

The insured died suddenly on September 21, 1934, as the result of coronary thrombosis (R. 78). There is a direct casual relationship between infectious matter in the blood stream such as that resulting from sinusitis and duodenal ulcer, and myocarditis followed by thrombosis [2] (R. 80–82, 128–129, 146).

Under the applicable statutes and regulations, the insured was not entitled to the policy sued on unless he was in good

[2] In 1933 the insured, having reference to his own condition, described degenerative myocarditis as "the most treacherous form of heart disease known, as long as compensation keeps up there are very fine manifest symptoms, and that when decompensation does occur it is usually complete and final" (R. 213). Substantially to the same effect, also, is the testimony of Dr. Thompson regarding the apparent absence of symptoms, except upon careful medical examination, of such a heart condition (R. 77).

health. In issuing the policy, the Veterans' Administration accepted as true, and therefore as proof of good health, the statements made by the insured regarding his health. Had the presence of any disability, actual or potential, been reflected upon the face of the application an investigation would have been made, and the policy would not have been issued had any disease or disability been found (R. 138, 139).

None of the evidence relied upon by petitioner tends to controvert that here summarized. Petitioner adduced testimony showing that the insured appeared to laymen to be in good health; that his wife and family were not aware that he had any disability or illness except colds; and that he had no actual disability preventing his employment as a medical officer in the Veterans' Bureau and his leading an apparently normal life otherwise (R. 20–27, 29, 34, 40–48, 50, 56–58, 182, 183).

Petitioner contends (Pet. 15–19) that this evidence, and evidence of conflicting statements of the insured regarding his health, and a number of reports of medical examinations claimed to reflect an absence of actual disability, warranted submission of the case to the jury. But the decisive issue at the trial was not whether the insured was disabled when he applied for the policy.[3] Whether he was then disabled was only one of the factors pertinent to the question of whether he was an insurable risk, and the statute vests in the Administrator of Veterans' Affairs exclusive jurisdiction to determine whether an applicant for insurance is an insurable risk. Sec. 5, World War Veterans' Act (U. S. C., Title 38, sec. 426); *Meadows* v. *United States*, 281 U. S. 271. There was ample information which, if known to the Administrator before the policy was issued, would have sustained refusal to issue the policy on the ground that the insured was not an acceptable risk.[3]

[3] Indeed, a number of the medical examination reports upon which petitioner relies to show an absence of actual disability contain diagnoses of heart disability, sinusitis, and duodenal ulcer, as follows: Myocardial degeneration beginning on October 10, 1928 (Pl. Ex. 10; R. 185). Chronic constipation and gastroptosis, on June 3, 1929 (Pl. Ex. 13; R. 186). Sinusitis, duodenal ulcer, and myocarditis on November 12, 1930 (Pl. Ex. 14; R. 188); on May 27, 1931 (Pl. Ex. 15; R. 189); and on February 27, 1933 (Pl. Ex. 18; R. 192).

Since there was no conflict in the evidence and, therefore, no issue for the jury on the decisive question of whether, in applying for the insurance, the insured knowingly denied illnesses and treatment material to the risk, the cases cited by petitioner (Pet. 9) are inapposite. In each of those cases, there was conflicting evidence on the issue of whether the insured could reasonably have known of his condition. *Bailey* v. *United States*, 92 F. (2d) 456 (C. C. A. 5); *United States* v. *Robins*, 117 F. (2d) 145 (C. C. A. 3); *Jones* v. *United States*, 112 F. (2d) 282 (C. C. A. 8). These cases turn upon the principle that an applicant for insurance is held only to a reasonable degree of honest recollection and interpretation in answering questions concerning the risk, a principle not denied in the present case. But "a normal man is not allowed to go too far in basing his good faith on assertions that he has forgotten what those in possession of their ordinary faculties would remember." *Guardian Life Ins. Co. of America* v. *Clum*, 106 F. (2d) 592, 594 (C. C. A. 3). In the present case, it cannot reasonably be regarded that the insured had forgotten the illnesses and treatment which he denied.[4]

2. Petitioner also asserts that, for lack of timely compliance with the provisions of Rule 9 of the court below, that court was without jurisdiction to hear and determine the appeal on its merits (Pet. 13). Rule 9 provides that no appeal will be considered unless a statement of points setting out each error asserted and intended to be urged is filed with the clerk of the district court for inclusion in the record on appeal. The rule specifies no time within which such statement must be filed, but it seems plainly to have been intended that the filing of it would be subject to the limitations and requirements governing the filing of the record.

By order of the district court, the time for filing the record herein was extended to November 24, 1940 (R. 227–228). A record complying in all respects with the requirements of the

[4] None of the other cases claimed by petitioner to be in conflict with the decision herein involves the question of fraud.

Federal Rules of Civil Procedure, particularly Rule 75 (a), (b), and (d), was filed on November 23, 1940. The circuit court of appeals permitted the filing thereafter, on February 28, 1941, of a supplemental record containing a statement of points required by Rule 9, and designed solely to comply with the provisions of that rule.[5]

Rule 9 does not purport to be jurisdictional, and the court has ruled in this case, in effect, that it was not intended to be. The rule was issued subsequent to the effective date of the Rules of Civil Procedure, and, doubtless, was intended to harmonize with them. Yet if Rule 9 were interpreted as urged by petitioner, it would seem to be in conflict with Rule 73 (a) of the Rules of Civil Procedure, since the latter rule provides that failure to take any action after filing of notice of appeal will not invalidate the appeal. Even if no portion of the record had been timely filed, the circuit court of appeals, in its discretion, might have permitted the filing of it out of time. Rule 73 (a) of the Rules of Civil Procedure; *Ainsworth* v. *Gill Glass and Fixture Co.*, 104 F. (2d) 83, 85 (C. C. A. 3); *Miller* v. *United States*, 117 F. (2d) 256 (C. C. A. 7); *Johnson* v. *Wilson*, 118 F. (2d) 557, 558 (C. C. A. 9).

It would seem to follow that the court might also permit the filing of part of the record out of time. But, in any event, Rule 75 (h) of the Rules of Civil Procedure expressly authorizes the supplementing of a record on appeal, as was permitted by the circuit court of appeals in the present case.

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[5] At the time the supplemental record was filed, neither party had filed a brief, and the case did not come on for oral argument until April 18, 1941. The Federal Rules of Civil Procedure do not require a statement of points where, as here, the complete record and all proceedings in the district court are included in the record on appeal. (Rule 75 (d)). These rules are apparently predicated upon the view that, if the entire record is before the Court of Appeals, fairness to the appellee does not require notice to him of points to be urged by appellant prior to service of the appellant's brief. In any event, the lack of prejudice to petitioner by reason of respondent's delayed compliance with Rule 9 in the present case is plain. She claims no prejudice.

## CONCLUSION

The decision of the Circuit Court of Appeals is correct. It presents no question of large public importance and turns upon its own facts. It is respectfully submitted, therefore, that the petition for a writ of certiorari should be denied.

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